

# Alternative HMO Plan

PLAN FEATURES	PARTICIPATING PROVIDERS/REFERRED
<b>Deductible</b> (per calendar year)	None, Individual None, Family
<b>Member Coinsurance</b>	Covered 100%
<b>Out-of-Pocket Maximum*</b> (per calendar year)	\$3,000 Individual \$6,000 Family
<b>Lifetime Maximum</b>	Unlimited, except where otherwise indicated
<b>Primary Care Physician (PCP) Selection</b>	Required
<b>Referral Requirements</b>	Required for all non-emergency, non-urgent and non-primary care physicians services, except for direct-access services.
PREVENTIVE CARE	PARTICIPATING PROVIDERS/REFERRED
<b>Routine Adult Physical Exams/Immunizations</b> (Age and frequency schedules apply.)	\$10 copay
<b>Well-Child Exams/Immunizations</b> (Age and frequency schedules apply.)	No copay per visit up to age 2 Childhood immunizations covered 100% birth through age 18
<b>Routine Gynecological-Care Exams</b> Includes Pap smear and related lab fees. One routine exam per 365 days.	\$10 copay
<b>Routine Mammograms</b> One baseline mammogram for females ages 35–39, and one annual mammogram for females age 40 and over.	Covered 100%
<b>Routine Digital Rectal Exams/Prostate-Specific Antigen Test</b> For males age 40 and over.	Member cost-sharing is based on the type of service performed and the place of service where it is rendered.
<b>Colorectal Cancer Screening</b> For all members age 50 and over. Frequency schedule applies.	Member cost-sharing is based on the type of service performed and the place of service where it is rendered.
<b>Routine Eye Exam</b> (Age and frequency schedules apply.)	\$65 copay per visit
<b>Routine Hearing Screening</b> Audiological services and hearing aids are covered every 48 months for children up to age 18.	\$10 per visit copay for basic hearing screening. Does not include comprehensive hearing exam. Limit one visit per calendar year.
PHYSICIAN FEATURES	PARTICIPATING PROVIDERS/REFERRED
<b>Primary Care Physician Visits†</b>	Office hours: \$55 copay After office hours/home: \$55 per visit copay
<b>Specialist Office Visits</b>	\$65 copay
<b>Maternity Ob/Gyn Visits</b>	\$55 copay for initial visit only; thereafter covered 100%
<b>Allergy Treatment</b>	\$20 copay
<b>Allergy Testing</b>	\$20 copay for 6-week supply of antigen (including shots)
DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS/REFERRED
<b>Diagnostic Laboratory</b> If performed as part of a physician's office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit cost-sharing.	\$65 copay
<b>Diagnostic X-ray</b> Outpatient hospital or other outpatient facility	\$65 copay for MRI, MRA, PET and CAT
EMERGENCY MEDICAL CARE	PARTICIPATING PROVIDERS/REFERRED
<b>Urgent Care</b>	\$75 copay
<b>Non-urgent Use of Urgent Care Provider</b>	Not covered
<b>Emergency Room</b>	\$200 copay; waived if admitted
<b>Non-emergency Care in an Emergency Room</b>	Not covered
<b>Ambulance</b>	Covered 100%
HOSPITAL CARE	PARTICIPATING PROVIDERS/REFERRED
<b>Inpatient Coverage**</b>	\$1,000 per admission copay; must be preauthorized
<b>Inpatient Maternity Coverage**</b>	\$1,000 per admission copay; must be preauthorized
<b>Outpatient Surgery**</b>	\$500 per visit copay; must be preauthorized

† Employees Benefits Council — Oklahoma Health Benefit — One PCP visit with blood work only for Oklahoma Health participants.

<b>MENTAL HEALTH SERVICES</b>		<b>PARTICIPATING PROVIDERS/REFERRED</b>
<b>Inpatient Biologically Based Mental Illness**</b>		\$1,000 per admission copay, must be preauthorized
<b>Inpatient Nonbiologically Based Mental Illness**</b>		\$1,000 per admission copay, must be preauthorized
<b>Outpatient Biologically Based Mental Illness**</b>		\$55 copay/PCP, \$65 copay/Specialist Single or group therapy, except for the biologically based diagnoses treated as other illnesses
<b>Outpatient Nonbiologically Based Mental Illness**</b>		\$55 copay/PCP, \$65 copay/Specialist Single or group therapy, except for the biologically based diagnoses treated as other illnesses
<b>ALCOHOLIC/DRUG ABUSE SERVICES</b>		<b>PARTICIPATING PROVIDERS/REFERRED</b>
<b>Inpatient Detoxification**</b>		\$1,000 per admission copay; must be preauthorized
<b>Outpatient Detoxification**</b>		\$65 per visit copay
<b>OTHER SERVICES</b>		<b>PARTICIPATING PROVIDERS/REFERRED</b>
<b>Skilled Nursing Facility**</b> Limited to 100 days per year.		No copay per admission
<b>Home Health Care</b>		Covered 100%
<b>Hospice Care**</b> — Inpatient		No copay per admission
<b>Hospice Care**</b> — Outpatient		No copay per admission
<b>Private-Duty Nursing</b>		Not covered unless preauthorized
<b>Outpatient Rehabilitation Therapy</b> (Includes speech, physical and occupational therapy.) Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment.		\$65 per visit copay
<b>Subluxation</b> Limited to 15 visits per calendar year.		\$65 per visit copay
<b>Durable Medical Equipment</b>		20% of contracted rate
<b>Diabetic Supplies</b>		Pharmacy cost-sharing applies if pharmacy coverage is included, otherwise PCP office visit cost-sharing applies.
<b>Dental</b>		Not covered
<b>Transplants</b>		\$65 copay. Coverage is provided at an Institute of Excellence (IOE) contracted facility only.
<b>FAMILY PLANNING</b>		<b>PARTICIPATING PROVIDERS/REFERRED</b>
<b>Infertility Treatment</b> Diagnosis and treatment of the underlying medical condition.		If identified; or 25% after professional services copay.
<b>Voluntary Sterilization</b> Including tubal ligation and vasectomy, excludes reversal of voluntary sterilization.		Subject to applicable service-type member cost-sharing.
<b>PHARMACY — PRESCRIPTION DRUG BENEFITS</b>		<b>PARTICIPATING PROVIDERS/REFERRED</b>
<b>Retail</b> Up to a 30-day supply or 100-unit doses, whichever is greater, at participating pharmacies.		\$20 copay for formulary generic drugs \$40 copay for formulary brand-name drugs \$70 copay for nonformulary brand-name and generic drugs
<b>Mail Order</b> Up to a 31- to 90-day supply or 100-unit doses, whichever is greater, at participating pharmacies.		\$40 copay for formulary generic drugs \$80 copay for formulary brand-name drugs \$140 copay for nonformulary brand-name and generic drugs
<b>No Mandatory Generic</b>		Member is responsible to pay the applicable copay only
<b>Plan Includes</b>		Contraceptive drugs and devices obtainable from a pharmacy Precertification included and step-therapy included
<b>Medical Spending Fund</b>		Not included

*Notice: In accordance with Oklahoma Regulation 365:40-5-22, this benefit summary provides information about any provisions in this health benefit plan that are different from those of last year.*

\* Member cost-sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers/referred out-of-pocket expenses resulting from the application of coinsurance percentage and copays (except any penalty amounts and pharmacy cost-sharing) may be used to satisfy the Out-of-Pocket Maximum. Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.

\*\*The member cost-sharing applies to all covered benefits incurred during a member's inpatient stay.